Supreme Court, U.S.
FILED
JAN 15 1986
JOSEPH F. SPANIOL, JR.
CLERK

No. 85-225

In the Supreme Court of the United States

OCTOBER TERM, 1985

OTIS R. BOWEN, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL., PETITIONERS

v.

MICHIGAN ACADEMY OF FAMILY PHYSICIANS, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

REPLY BRIEF FOR THE PETITIONERS

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Respondents contend that the district court had jurisdiction in this case to review one aspect of the determination by the carrier of the amount of benefits payable for certain physicians' services under the Part B Medicare Program. However, as we have explained in our opening brief, judicial review of such matters is foreclosed by two separate provisions of the Social Security Act, 42 U.S.C. 1395ff and 405(h). Respondents' arguments for avoiding these statutory preclusions of review already have been rejected by this Court in *United States* v. *Erika, Inc.*, 456 U.S.

201 (1982), and *Heckler* v. *Ringer*, No. 82-1772 (May 14, 1984).

1. Respondents argue (Br. 23-32) that 42 U.S.C. 1395ff does not foreclose review of "statutory" questions arising in connection with the determination of the amount of benefits payable under the Part B Program. They contend that Section 1395ff bars judicial review only of those issues (essentially factual in nature) that are within the authority of the carrier hearing officer to resolve in the "fair hearing" required by 42 U.S.C. 1395u(b)(3)(C), and that a court therefore may exercise jurisdiction under 28 U.S.C. 1331 to consider legal issues relating to the carrier's benefit determinations under the Part B Medicare Program. However, as respondents appear to concede (Br. 32-33), these very arguments were squarely presented and unanimously rejected in *Erika*.

a. In *Erika*, the plaintiff challenged the carrier's calculation of the prevailing charge for particular Part B services. That prevailing charge, which places a ceiling on the amount of benefits that may be paid for covered services (42 U.S.C. 1395u(b)(3); 42 C.F.R. 405.502; see Pet. Br. 6), is to be established at the level that "would cover 75 percent of the customary charges made for similar services in the same locality during the last preceding calendar year" (42 U.S.C. 1395u(b)(3)). In *Erika*, the plaintiff contended that the carrier's calculation of the prevailing charge level as of one fixed date in the preceding calendar year, without taking into account subsequent price increases, violated the requirement in the language just quoted that the prevailing charge level reflect the customary charges made "during" the preceding year. The Court of Claims held that it had jurisdiction to consider this "statutory" challenge to

the carrier's method of determining the amount of benefits (*Erika, Inc.* v. *United States*, 634 F.2d 580, 585-588 (Ct. Cl. 1980)); concluded that the carrier's approach was inconsistent with the statute (*id.* at 588-589); and remanded the case to the carrier to recalculate the prevailing charge level in a manner consistent with the court's interpretation of 42 U.S.C. 1395u(b)(3) (634 F.2d at 589, 591). See 456 U.S. at 205-206. This Court, however, unanimously reversed, holding that 42 U.S.C. 1395ff completely barred the Court of Claims from exercising jurisdiction in the case. 456 U.S. at 206-211.

Like the plaintiff in *Erika*, respondents challenge the carrier's determination of the prevailing charge level that establishes a ceiling on the amount of benefits payable for particular Part B services. The only difference is that respondents contend that the carrier's approach is inconsistent with the statutory requirement that the services on the basis of which the prevailing charge is calculated be "similar," while the plaintiff in *Erika* argued that the carrier's determination was inconsistent with the requirement that such similar services have been rendered "during" the preceding calendar year. This difference has no bearing on the availability of judicial review, and *Erika* therefore controls here.

b. Moreover, the arguments presented to this Court in *Erika* were precisely those that respondents now advance in this case. The respondent in *Erika* argued that Section 1395ff does not bar judicial review of "statutory" challenges to "administrative actions which might have an effect on the benefit determinations" (*Erika* Resp. Br. at 26), even though it conceded that Section 1395ff does bar review of the carrier's factual determinations. See generally *Erika*

Resp. Br. at I, 6-7, 26-28, 40-41. Essentially identical arguments were made in a brief amicus curiae filed by the American Academy of Family Physicians, the parent organization of the Michigan Academy of Family Physicians, a respondent in this case (see Resp. Br. 2). The family physicians' brief argued that 42 U.S.C. 1395ff should not be construed to bar judicial review of regulatory and statutory questions, even if review of the carrier's essentially arithmetic computation of benefit amounts is foreclosed (*Erika* Amicus Br. at 12-13, 15-18, 23, 25-27), and it cited the district court's decision in the instant case as an example of the sort of statutory challenge to a carrier's actions that, like the claim in *Erika* itself, should not be barred from judicial review under Section 1395ff (*Erika* Amicus Br. at 28). In addition, the American Academy of Family Physicians pointed out that under governing regulations and the Carrier's Manual,[1] the carrier hearing officer is bound by provisions of the Medicare Act, implementing regulations, and instructions issued by the Health Care Financing Administration; and it argued that 42 U.S.C. 1395ff should not be construed to bar judicial review of any such issues that the hearing officer does not have authority to pass upon. See *Erika* Amicus Br. at 14-17. Respondents repeatedly make this same argument in this case. See Resp. Br. 4-5, 16-17, 19, 24-25, 26, 28, 29, 30.[2]

This Court unanimously rejected these arguments in *Erika*, and they are no more persuasive now.

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[1] See 42 C.F.R. 405.860; Department of Health and Human Services, *Medicare Part B Carrier's Manual* § 12016, quoted at Resp. Br. 4-5.

[2] However, the court of appeals in this case did not rest its jurisdictional ruling on the scope of the carrier hearing officer's discretion; the court did not even mention that point. See Pet. App. 6a-11a, 17a-22a.

Nothing in the text or legislative history of 42 U.S.C. 1395ff suggests a congressional intent to distinguish, for purposes of judicial review, between issues of fact on the one hand and issues of statutory construction and the validity of regulations on the other. Section 1395ff provides for judicial review pursuant to 42 U.S.C. 405(g) of the "amount of benefits" payable under Part A of the Medicare Program, but does not provide for such review of the "amount of benefits" under Part B. Section 405(g) in turn specifically provides for judicial review of the validity of regulations issued by the Secretary that have a bearing on the decision on an individual claim for benefits,[3] and the legislative history of 42 U.S.C. 405(g) makes clear that it was intended to establish the mechanism for obtaining judicial review of other questions of law that may be involved in individual claims.[4] Accordingly, when Congress affirmatively authorized judicial review of the amount of benefits under Part A pursuant to 42 U.S.C. 405(g), it thereby authorized judicial review of questions of law, including the validity of regulations issued by the Secretary, that relate to the Secretary's calculation of the amount of benefits. The corresponding *foreclosure* of judicial review of the "amount of benefits" under Part B, which this Court recognized in *Erika*, therefore also extends to questions of statutory construction and the

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[3] Section 405(g) provides in part: "[W]here a claim has been denied by the Secretary * * * because of failure of the claimant * * * to submit proof in conformity with any regulation prescribed under subsection (a) of this section, the court shall review only the question of conformity with such regulations and the validity of such regulations."

[4] See H.R. Rep. 728, 76th Cong., 1st Sess. 43 (1939); S. Rep. 734, 76th Cong., 1st Sess. 52 (1939).

validity of regulations that may affect the carrier's determination of the amount of benefits payable under Part B.

It does not matter for these purposes that, as respondents repeatedly stress, the carrier hearing officer is bound to follow the provisions of the Act, implementing regulations, and instructions issued by the Secretary. Compare *Ringer*, slip op. 4. This requirement simply reflects the practical necessity that the Secretary must retain ultimate administrative responsibility for legal issues that arise in connection with the adjudication of claims under the vast Part B Medicare Program and that the carrier's personnel are not free to disagree with his resolution of these matters. The purpose of an administrative hearing is not to resolve such questions of law in any event, especially since they do not turn on circumstances unique to a particular claimant. See *Heckler* v. *Campbell*, 461 U.S. 458, 467-468 (1983). The provisions of the regulations and Carrier's Manual limiting the authority of the carrier hearing officer with respect to questions of law therefore have no bearing whatsoever on the availability of judicial review of such questions. Cf. *Schweiker* v. *McClure*, 456 U.S. 188, 197 (1982).[5]

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[5] Contrary to respondents' apparent contention (Resp. Br. 24), the carrier hearing officer in *Erika* held that the issues involved in that case—whether retroactive adjustments could be made in the reimbursement for certain supplies and whether the prevailing charge level could be adjusted upward to account for price increases during the year—were beyond his authority to determine, in light of instructions from the Secretary that prohibited such adjustments. *Erika* Pet. App. at 46a-48a, 78a-86a. In fact, the hearing officer specifically cited the regulation (42 C.F.R. 405.860) that required him to follow the provisions of the Act, regulations, and instructions. *Erika* Pet. App. at 40a.

Thus, as this Court recently observed, in distinguishing *Erika* from a case in which Congress was held not to have foreclosed judicial review of statutory questions relating to benefit determinations, the circumstances of the enactment of 42 U.S.C. 1395ff " 'confirm[ed]' Congress' intent *absolutely* to preclude review." (*Lindahl* v. *OPM*, No. 83-5954 (Mar. 20, 1985), slip op. 21 n.28 (emphasis added), quoting *Erika*, 456 U.S. at 208). The Court followed *Erika* only two years ago in *Ringer*, holding that a statutory challenge to the carrier's actions and the validity of a formal ruling by the Secretary was foreclosed under Part B. *Ringer*, slip op. 5 n.4, 6-7 & n.7. Moreover, since *Erika* was decided, Congress has revisited the Part B Medicare Program on numerous occasions and made extensive revisions in that Program.[6] But although proposals have been made to provide for judicial review under Part B in certain circumstances, Congress has not amended 42 U.S.C. 1395ff to overrule *Erika* and provide for even limited judicial review of such matters. Compare *Merrill Lynch, Pierce, Fenner & Smith* v. *Curran*, 456 U.S. 353, 381-382 (1982).[7] There accordingly is no basis

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[6] See Pub. L. No. 97-248, §§ 104(a), 113(a), 128(d)(1), 96 Stat. 336, 340, 367; Pub. L. No. 98-369, §§ 2306, 2339, 98 Stat. 1070, 1093; Pub. L. No. 98-617, § 3(a)(1), (b)(5) and (6), 98 Stat. 3295-3296; Pub. L. No. 99-107, § 5(b), 99 Stat. 479.

[7] On September 11, 1985, the House Committee on Energy and Commerce reported a bill that would amend 42 U.S.C. 1395ff to provide for an ALJ hearing on a Part B claim if the amount in controversy is $500 or more and judicial review if the amount in controversy is $1000 or more. H.R. 3101, 99th Cong., 1st Sess. § 132. See H.R. Rep. 99-265, 99th Cong., 1st Sess. 51 (1985). This provision then was included as Section 9212 of H.R. 3128, 99th Cong., 1st Sess. (1985) (the

for respondents' contention that the Court should now recognize a right of judicial review where it previously held such review to be barred in *Erika*—and to do so without regard to the amount-in-controversy and other limitations on judicial review under 42 U.S.C. 1395ff and 405(g), as the court of appeals permitted in this case.[8]

Consolidated Omnibus Budget Reconciliation Act of 1985). See 131 Cong. Rec. H13125 (daily ed. Dec. 19, 1985). That bill was reported by the Conference Committee on December 19, 1985 (*id.* at H13093), but the House and Senate are in disagreement concerning approval of the Conference Report. See *id.* at H13302, S18400-S18401.

The portions of the committee reports discussing the Medicare appeal provisions make clear that Congress is of the view that, at the present time, "[t]he law does not provide for any * * * judicial review for a [P]art B claim." H.R. Conf. Rep. 99-453, 99th Cong., 1st Sess. 452-453 (1985), *reprinted in* 131 Cong. Rec. H13238 (daily ed. Dec. 19, 1985); H.R. Rep. 99-265, *supra*, at 51-52. See also *Health Financing: Hearings on Deficit Reduction Proposals—Part B of Medicare, Before the Subcomm. on Health and the Environment of the House Comm. on Energy and Commerce*, 99th Cong., 1st Sess. 476 (1985) (discussing *Erika*); *id.* at 427, 458, 472-493, 531.

[8] The suggestion by respondents (Br. 26-27) and amicus American Medical Association (AMA Br. 7-8, 11) that *Erika* is distinguishable because this case does not involve an actual claim for benefits is completely without merit. Respondents stress (Br. 27) that all the court of appeals did was to remand the case to the Secretary with instructions to determine the prevailing charge by reference to "similar" services, and that it did not become involved in the adjudication of particular benefit claims. Respondents ignore the fact that this also was the only relief granted by the Court of Claims in *Erika*; the court there likewise eschewed any role in the determination of individual claims. 634 F.2d at 589-591; see 456 U.S. at 206.

In addition, although respondents have not sought an actual award of benefits from the courts in this case, they have sought judicial review of a regulation that pertains to

2. Respondents make only a passing effort (Br. 20-23) to avoid the force of 42 U.S.C. 405(h), which is incorporated into the Medicare Program by 42 U.S.C. 1395ii and independently bars judicial review in this case. The second sentence of Section 405(h) provides that "no findings of fact or decision of the Secretary shall be reviewed by any * * * tribunal * * * except as herein provided"—*i.e.*, except as provided in the Social Security Act itself. Because nothing in the Social Security Act provides for judicial review under Part B, such review is foreclosed by the second sentence of Section 405(h). Respondents argue (Br. 21) that the second sentence of Section 405(h) does not apply in this case because decisions on claims for benefits under Part B are made by the carriers, not the Secretary. See also AMA Br. 13-14. This argument, however, ignores the fact that the carrier simply acts as the Secretary's agent in adjudicating Part B claims, and the Secretary is the real party in interest in any litigation arising under the program. See *Erika*, 456 U.S. at 206 n.4. Respondents' argument is especially misplaced in this case,

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the prevailing charge aspect of benefit determinations, which is an integral part of a claim for benefits under Part B. A claimant cannot avoid the total preclusion of review under 42 U.S.C. 1395ff by splitting off one legal issue that may have a bearing on his claim for benefits and seeking judicial review on only that discrete matter. See *Ringer*, slip op. 5 n.4, 12, 18-19. Moreover, in *Erika*, the carrier hearing officer applied what he understood to be binding instructions from the Secretary that limited the amount of reimbursement. *Erika* Pet. App. at 44a-46a, 80a-82a. The Court of Claims reviewed several of those instructions, and determined that they were not binding. 634 F.2d at 590-591. Thus, contrary to the AMA's assertion (AMA Br. 8 n.4), *Erika* cannot be distinguished on the ground that it did not involve a challenge to instructions issued by the Secretary.

because they brought this suit to challenge a regulation promulgated by the *Secretary* that allows separate prevailing charge screens.

The third sentence of Section 405(h), as incorporated by 42 U.S.C. 1395ii, provides that "[n]o action" shall be brought under 28 U.S.C. 1331 "to recover on any claim arising under" the Medicare Act. Respondents first maintain (Br. 21) that this sentence is inapplicable in this case because they are not seeking to recover on a claim for benefits, but instead are challenging the mechanism for determining the prevailing charge level. However, as we have explained (Pet. Br. 6, 24-25), the prevailing charge level is an integral component in the determination of the amount of benefits payable on a particular claim. Accordingly, contrary to the AMA's assertion (AMA Br. 17), respondents' challenge to the prevailing charge level is "inextricably intertwined" with the claim for benefits. Under *Ringer* (slip op. 11-13, 19-23), a claimant cannot separate out one issue bearing on his claim for benefits in this manner and seek judicial review of that issue in a separate action under 28 U.S.C. 1331. See Pet. Br. 35-36.

Respondents next argue (Br. 22-23) that the third sentence of Section 405(h) does not bar this suit under 28 U.S.C. 1331 because review is not otherwise available under 42 U.S.C. 405(g). However, in *Ringer*, this Court explicitly rejected the contention that the application of the sweeping jurisdictional bar in Section 405(h) depends on whether Congress has authorized judicial review under another provision of the Social Security Act. *Ringer*, slip op. 19. Indeed, the very purpose of Section 405(h) is to preclude judicial review except where and to the extent it is affirmatively authorized under the Social Se-

curity Act, pursuant to 42 U.S.C. 405(g). S. Rep. 734, *supra*, at 52; H.R. Rep. 728, *supra*, at 43-44.[9] Thus, Section 405(h) reinforces what is in any event clear from the text and legislative history of 42 U.S.C. 1395ff: judicial review of the carrier's determination of the prevailing charge level in this case is foreclosed.

3. Although it is not directly involved here, respondents also present (Br. 7-12, 33-34) a defense of the court of appeals' holding on the merits. The court of appeals held that the regulation authorizing the establishment of separate charge screens (42 C.F.R. 405.504(b)) is inconsistent with the requirement in 42 U.S.C. 1395u(b)(3) that the prevailing charge level be calculated on the basis of charges for

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[9] Contrary to the AMA's contention (AMA Br. 17-19), the fact that Congress, in 42 U.S.C. 1395ii, provided that Section 405(h) and certain other provisions of Title II shall apply to the Medicare Program "to the same extent as they are applicable with respect to [title] II" does not suggest that Section 405(h) has a less sweeping application under the Medicare Program. To the contrary, Congress made Section 405(h) applicable "to the same extent" as under Title II, where it absolutely bars the exercise of jurisdiction under 28 U.S.C. 1331 and permits judicial review only pursuant to 42 U.S.C. 405(g). See *Weinberger* v. *Salfi*, 422 U.S. 749, 756-762 (1975). Congress provided for judicial review pursuant to 42 U.S.C. 405(g) under the Medicare Act in certain circumstances. See 42 U.S.C. 1395ff. It therefore is reasonable to assume that Congress intended Section 405(h) to have the effect under the Medicare Act, as under Title II, of barring the exercise of jurisdiction under 28 U.S.C. 1331 and to allow judicial review only where it is affirmatively authorized by 42 U.S.C. 1395ff and 405(g). Moreover, the Court enforced the preclusion of review in Section 405(h) in *Ringer*, a Medicare case, without suggesting that it does not apply with full force under the Medicare Program. See *Ringer*, slip op. 11-12, 19-23.

"similar" services (Pet. App. 11a-14a). Respondents' arguments warrant a brief response.

Respondents' submission proceeds as if the decision by the carrier in Michigan to adopt separate charge screens is an aberration under the Medicare Program. In fact, however, separate screens for specialists and general practitioners are the rule, not the exception. A study prepared for the responsible congressional committees in 1983 stated that in the period between July 1, 1981 and June 30, 1982, "Medicare carriers recognized specialty reimbursement differentials in all areas of the country except for Florida, Kansas, North Dakota, South Dakota, and the area of New York served by Blue Shield of Western New York." Staffs of the Sen. Comm. on Finance and the House Comms. on Ways and Means and Energy and Commerce, 98th Cong., 1st Sess., *Background Data on Physician Reimbursement Under Medicare* 74 (Joint Comm. Print 1983) [hereinafter cited as Comm. Print].[10] There was no suggestion that these differing charge screens are unlawful under 42 U.S.C. 1395u, as respondents maintain. See Comm. Print 10, 95-96.

Moreover, although Congress has extensively revised the Part B physician reimbursement provisions in 42 U.S.C. 1395u in a number of respects in recent years (see page 7 and note 6, *supra*), Congress has

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[10] The study states: "Differentials between general practitioners and specialists were already recognized by many private insurance plans at the time Medicare was enacted. Over the years there has been some concern that the general policy among third parties, including Medicare, of recognizing such fee differentials has tended to encourage increased specialization. However, it has been suggested by some that specialists may provide a different type of higher quality service." Comm. Print 74.

not amended that Section to prohibit the use of separate charge screens, which have been authorized by the Secretary's regulations since 1967.[11] To the contrary, in Section 2309 of the Deficit Reduction Act of 1984, Pub. L. No. 98-369, 98 Stat. 1074-1075, Congress directed the Office of Technology Assessment to "conduct a study of physician reimbursement under the medicare program"; this study is to include findings and recommendations regarding how "payment amounts and other program policies under part

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[11] The regulation already was in effect in 1972, when Congress amended 42 U.S.C. 1395u to add the sentence under which respondents now argue that the regulation is invalid. See 20 C.F.R. 405.504(b) (1972); Pub. L. No. 92-603, § 224(a), 86 Stat. 1395. That sentence provides that no charge shall be found to be reasonable if it exceeds "the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during the last preceding calendar year * * *." This sentence was incorporated essentially verbatim from, and was intended to ratify, a provision in the then-existing regulations that placed a limit on the reasonable charge. See S. Rep. 92-1230, 92d Cong., 2d Sess. 191-194 (1972). The regulatory provision Congress incorporated into the Act was subsection (a) of 20 C.F.R. 405.504 (1972). Subsection (b) of that same regulation contained the authorization for separate charge screens that respondents challenge in this case. Accordingly, Congress must have been aware when it enacted the amendments in 1972 that the use of separate charge screens was a "methodology acceptable to the Secretary" within the meaning of subsection (a) of the regulation and, therefore, within the meaning of the sentence it added to 42 U.S.C. 1395u. Congress's failure to amend 42 U.S.C. 1395u to prevent the use of separate charge screens in these circumstances thus lends considerable support to the reasonableness of the Secretary's interpretation of the Act as permitting the use of such screens. Compare *Merrill Lynch, Pierce, Fenner & Smith* v. *Curran*, 456 U.S. at 381-382.

B * * * may be modified" to, inter alia, "eliminate inequities in the relative amounts paid to physicians by type of service, locality, and *specialty*" (§ 2309 (a)(1)(A) (emphasis added)).[12] There is no suggestion in this legislation that any differences in the relative amounts paid to physicians depending upon their specialty was any less consistent with the Act than differences that might occur as a result of "type of service" or "locality." See H.R. Conf. Rep. 98-861, 98th Cong., 2d Sess. 1318-1319 (1984). Congress simply chose to study the matter to determine whether possible adjustments should be made in the established reimbursement scheme. Compare *Heckler* v. *Day*, No. 82-1371 (May 22, 1984), slip op. 9-10.

Against the background of Congress's close scrutiny of the Medicare Part B Program and its frequent amendments to the governing statutory provisions, it was an "unwarranted judicial intrusion into this pervasively regulated area" (*Day*, slip op. 15) for the court of appeals to invalidate a reimbursement method that has been a feature of the Part B Program virtually since its enactment.

4. Finally, respondents argue (Br. 32-34) that the regulation authorizing the use of different charge screens based on a physician's specialty violates the Due Process Clause, and they contend (Br. 35-43) that Congress cannot foreclose judicial review of that contention. However, for the reasons stated in our opening brief (at 43-44), respondents' constitutional arguments are too insubstantial to support subject matter jurisdiction. See *Ringer*, slip op. 5 n.4. Respondents cite (Br. 34) testimony by several wit-

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[12] The report was to be submitted to Congress by December 31, 1985 (98 Stat. 1075), but we have been informed that it has not yet been completed.

nesses in this case to the effect that the use of separate charge screens causes more physicians to become specialized, affects a patient's choice of a physician, and leads to increased costs. Even if this testimony is credited, neither the Medicare Act nor an implementing regulation is unconstitutional because it may have those incidental consequences.

The purpose of the Medicare Act is to provide a program of insurance for a portion of the reasonable medical charges actually incurred by a beneficiary, based on experience in the community. It therefore plainly is rational for Congress, through the Secretary, to authorize carriers to utilize differing charge screens based on existing differentials in the charging patterns of specialists and others. Moreover, Congress rationally could determine that services furnished by persons with certain types of specialization are sufficiently different from comparable services furnished by others to warrant different levels of reimbursement. The question in respondents' constitutional challenge to the regulation is not whether Congress (or even the Secretary or the carrier) has current empirical data to establish the validity of these premises. The question is whether Congress rationally could have believed them to be valid. *Vance* v. *Bradley*, 440 U.S. 93, 109-112 (1979). Respondents have made no showing whatever that Congress could not rationally do so.[13]

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[13] Respondents and the AMA suggest (Br. 35, 37; AMA Br. 19-25) that, under the three-part balancing test of *Mathews v. Eldridge*, 424 U.S. 319, 335 (1976), the Due Process Clause requires the availability of judicial review even in the absence of a constitutional question. This contention was not raised by respondents in the court of appeals, and it is, in any event, without merit. This Court, applying the three-part balancing test of *Mathews* v. *Eldridge, supra*,

For the foregoing reasons and the additional reasons stated in our opening brief, the judgment of the court of appeals should be reversed.

Respectfully submitted.

CHARLES FRIED
Solicitor General

JANUARY 1986

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already has rejected the contention that the Due Process Clause prevents Congress from according finality to the carrier's determination of Part B Medicare claims. *Schweiker* v. *McClure*, 456 U.S. at 198-200. Nor has this Court elsewhere suggested that it would be unconstitutional for Congress to foreclose judicial review of nonconstitutional issues that might arise in connection with the adjudication of claims for statutory benefits. See *Johnson* v. *Robison*, 415 U.S. 361, 366-367 (1974); *Salfi*, 422 U.S. at 762; *Lindahl* v. *OPM*, slip op. 8-21. Compare *Northern Pipeline Co.* v. *Marathon Pipe Line Co.*, 458 U.S. 50, 77-87 (1982) (plurality opinion).

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